

PATIENT REGISTRATION FORM

Everett Ear, Nose, and Throat - Sinus and Allergy

PATIENT INFORMATION (please print)

Glenn W. Drumheller, DO --- Thomas J. Mueller, MD

Last Name	First Name	MI	<input type="checkbox"/> Male <input type="checkbox"/> Female
DOB: / /	Social Security # - -	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)	
Street Address	City	ST	Zip
Mailing Address <input type="checkbox"/> Same	City	ST	Zip
Home Phone	Cell Phone	Work Phone	
<i>Everett ENT may use the voice mail of any and all numbers provided by patient for reminder calls and other patient matters.</i>			
Email			

Minors (Patient's under 18) and Special Needs Patients		
Father: _____	Mother: _____	Guardian: _____
Special circumstances:		
Patient Employer	Occupation	Not employed <input type="checkbox"/> Retired <input type="checkbox"/>
Primary Care Doctor	Clinic	Phone #
Referring Doctor <input type="checkbox"/> Same	Clinic	Phone #
How did you hear about Everett ENT <input type="checkbox"/> Doctor <input type="checkbox"/> ER <input type="checkbox"/> Newspaper <input type="checkbox"/> Phone Book <input type="checkbox"/> Insurance <input type="checkbox"/> Internet <input type="checkbox"/> Everett ENT website <input type="checkbox"/> Friend / Family <input type="checkbox"/> Other _____		

PAYMENT INFORMATION Please provide all insurance cards to the receptionist and list below which insurance is primary and secondary.

Person responsible for bill: <input type="checkbox"/> Patient, <input type="checkbox"/> Parent/Guardian, if under 18 Name _____		<input type="checkbox"/> CASH PAY (no insurance)
PRIMARY INSURANCE _____ Does insurance plan require a referral to see a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No Does it require a co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amount? _____ Subscriber <input type="checkbox"/> Patient - <i>No need to fill out subscriber info below</i> <input type="checkbox"/> Person other than patient - <i>Please provide subscriber info below</i>	Please show insurance card to receptionist <input type="checkbox"/> Ins. card provided <input type="checkbox"/> NO Ins. card provided – <i>provide INS info below</i> Insured ID# _____ Group# _____ Group Name _____	
Subscriber name _____ Relationship to Patient _____ DOB ____/____/____ (required)		
Subscriber address: <input type="checkbox"/> Same _____ Subscriber Phone # _____		
Subscriber SSN# _____ Subscriber Employer _____ Phone # _____		
SECONDARY INSURANCE _____ Does insurance plan require a referral to see a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No Does it require a co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amount? _____ Subscriber <input type="checkbox"/> Patient - <i>No need to fill out subscriber info below</i> <input type="checkbox"/> Person other than patient - <i>Please provide subscriber info below</i>	Please show insurance card to receptionist <input type="checkbox"/> Ins. card provided <input type="checkbox"/> NO Ins. card provided – <i>provide INS info below</i> Insured ID# _____ Group# _____ Group Name _____	
Subscriber name _____ Relationship to Patient _____ DOB ____/____/____ (required)		
Subscriber address: <input type="checkbox"/> Same _____ Subscriber Phone # _____		
Subscriber SSN# _____ Subscriber Employer _____ Phone # _____		

Patient or Guardian Initial _____ Turn over ⇨.

FINANCIAL POLICY

Everett ENT is committed to providing the highest level of quality medical care and personal service to our patients. For every commitment, there is an obligation. We feel it is the patient's or parent/guardian's responsibility to meet their financial obligations. We see patients from many different insurance plans, it is impossible for us to know all the covered benefits, co-pays, and deductibles for each plan. In addition, insurance companies will not guarantee payment to us. While it is our intention to assist patients, it is the patient's responsibility to ensure that all services rendered are covered on your insurance plan.

Patients Without Insurance Coverage - Payment at the time of service is required. We offer a 15% discount to patients who pay for their services in full at the time of their visit.

Patients With Insurance Coverage - We bill all insurance carriers we are contracted with on behalf of the patient. Co-pays must be paid at the time of service, as required by the insurance company. If the co-pay is not paid at the time of service, the patient may be subject to a \$25.00 processing fee. The patient will be responsible for all amounts due including deductibles, co-payments and co-insurance amounts. If your insurance company requires a referral to see a specialist, it is the patient's responsibility to obtain that referral. If seen without a referral, the reduced benefit is the patient's responsibility.

Services Provided to Minors - A "minor" is defined as a patient under the age of eighteen years of age, who is not considered legally emancipated from his or her parent or guardian. We realize that there may be an arrangement regarding who is responsible when paying for medical services provided to a minor. However, it is our policy that the parent or guardian who requests medical care for the minor is the financially responsible party.

Collection Accounts - If your account is sent to our collection agency, the collections account must be paid off AND all future visits will be paid in full at the time of service, regardless of Insurance coverage. If your account is turned over to our collection agency you will be charged a *Patient Release Fee of \$50.00*.

Returned Checks - There will be a \$30.00 charge for all returned checks added directly to your account. If the account is not paid within 15 days of the returned check charge, the account will automatically be turned over to our collection agency.

Cancellation Fee - There will be a \$25.00 fee for all missed appointments and/or for any appointments that are cancelled with less than 24 hours notice. There will be a \$200.00 fee for all missed surgeries and/or for surgeries that are cancelled with less than a 14 day notice. Allergy testing and/or re-testing appointments that are missed or not cancelled within 48 hours are also subject to a \$50.00 fee.

Shipping & Handling/Billing/Re-Billing Fee - If you are requesting your vials mailed to you instead of picking them up in our office, we require a \$3.00 Shipping and handling fee. You may choose not to pay the shipping and handling fee prior to your vials being mailed. However, there will be an additional \$5.00 billing fee for mailing a statement to you. For patient balances that are not paid within 30 days, a \$5.00 re-billing fee will be added to your balance. You will be responsible for this balance.

Initial I have read and agree to the terms set forth in this financial policy. I am financially responsible for all balances due.

NOTICE OF PRIVACY PRACTICES (HIPAA)

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer or the Practice Manager. *Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. A copy can be provided on request*

The patient's express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, I must specifically authorize the release of this information relating to such diagnosis, testing or treatment.

Initial I acknowledge that I understand the Notice of Privacy Practices (HIPAA).

PERSON(S) AUTHORIZED TO SPEAK WITH ON YOUR BEHALF

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance provider and primary care doctor, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with if needed. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do not Release Information" box below.

I give the following named person(s) authorization to take messages or speak with the office of Everett E.N.T. on my behalf regarding (please check all items authorized and circle relationship to patient).

All Information / *Limit to this information:* Appointments Financial Medical Insurance Emergency Contact Only

Name of authorized person: _____ Spouse / Parent / Other _____

Name of authorized person: _____ Spouse / Parent / Other _____

NO ONE AUTHORIZED - Do not release information to anyone other than primary care doctor and insurance

Initial I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

I hereby authorize Everett ENT, PS to release any medical information to my primary and/or secondary insurance company that is necessary to process my medical claim. My signature also authorizes any insurance benefits to be paid on my behalf. I hereby agree to full responsibility for all expenses incurred by myself or minor child. In the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees, if necessary. My signature also gives my consent for care and treatment. I agree to above policies and certify that all patient information provided is correct.

Patient or Guardian Signature _____ Date _____

Guardian signature required if patient is under 18 years of age - indicate relationship